Hubris to Humility: Medical Power in Medical Futility Conflicts

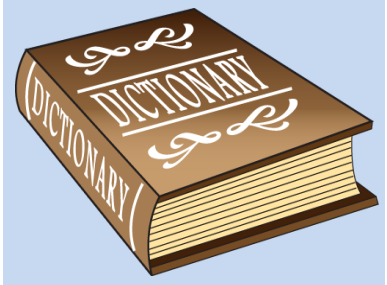
Spectrum Health 2014 Ethics Conference
Grand Rapids, Michigan

Thaddeus Mason Pope, J.D., Ph.D.
Hamline University Health Law Institute
Saint Paul, Minnesota

My title

Hubris

Excessive self-confidence



Humility

Not thinking you are better

Broader trends in patient power

ZocDoc
Get well sooner.

Consumer Reports

RateMDs.com

healthgrades
How America finds a doctor.

vitals℠

Breaking Down the Payments

Medicare disclosed payments of $77 billion in 2012 to more than 880,000 doctors and other medical providers for services and equipment. The breakdown for the top 15 medical specialties ranked by average paid to individual billers:

Provider type	Number of providers	Total paid in millions	Average amount paid per provider
Hematology/oncology	7,374	$2,703.9	$366,677
Radiation oncology	4,135	1,499.6	362,666
Ophthalmology	17,067	5,585.0	327,239
Medical oncology	2,613	806.6	308,702
Portable X-ray	7	2.0	288,020
Rheumatology	4,053	1,044.5	257,701
Nephrology	7,503	1,685.6	224,657
Cardiology	22,241	4,965.3	223,248
Dermatology	10,507	2,235.3	212,745
Interventional pain management	1,856	366.1	197,229
Peripheral vascular disease	74	14.3	193,441
Hematology	687	127.6	185,757
Cardiac electrophysiology	1,117	204.0	182,641
Vascular surgery	2,696	485.3	180,019
Urology	8,791	1,385.4	157,589

Source: Centers for Medicare and Medicaid Services — The Wall Street Journal

Palliative Care Information Act
NY Pub. Health L. 2997c

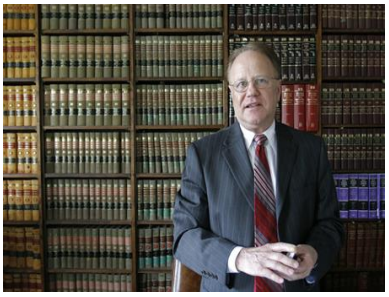
ACP
American College of Physicians

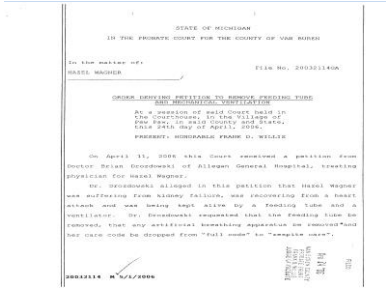
STATEMENT OF PRINCIPLES ON THE ROLE OF GOVERNMENTS IN REGULATING THE PATIENT-PHYSICIAN RELATIONSHIP

A Statement of Principles of the American College of Physicians
July 2012

Hubris to humility in futility

Brian Drozdowski





STATE OF MICHIGAN

IN THE PROBATE COURT FOR THE COUNTY OF VAN BUREN

In the matter of:
HAZEL WAGNER
File No. 2003211400

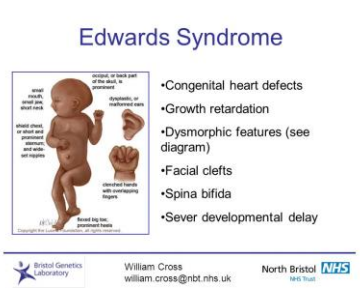
ORDER DENYING PETITION TO REMOVE FEEDING TUBE AND MECHANICAL VENTILATION

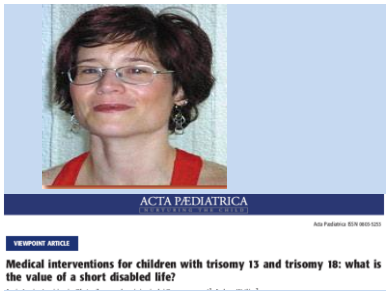
At a session of said Court held in the Courthouse, in the Village of Paw Paw, in said County and State, this 24th day of April, 2006.

PRESENT: HONORABLE FRANK D. WILLIS

On April 11, 2006 this Court received a petition from Doctor Brian Drozdowski of Allegan General Hospital, treating physician for Hazel Wagner.

Dr. Drozdowski alleged in this petition that Hazel Wagner was suffering from kidney failure, was recovering from a heart attack and was being kept alive by a feeding tube and a ventilator. Dr. Drozdowski requested that the feeding tube be removed, that any artificial breathing apparatus be removed and her care code be dropped from "full code" to "complete care".





PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

PART 204

MEDICAL GOOD-FAITH PROVISIONS

333.20401 Short title of part.

Sec. 20401. This part shall be known and may be cited as the "medical good-faith provisions act".

History: Add. 2013, Act 57, Eff. Sept. 10, 2013.

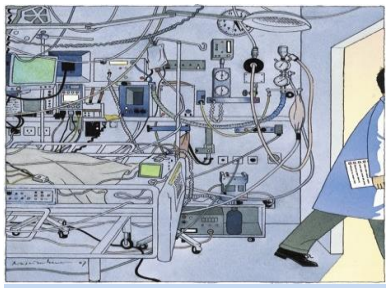
Popular name: Act 368

Roadmap

"I'm afraid there's really very little I can do."

Surrogate driven over-treatment

Clinician	Surrogate
CMO	LSMT



Prevalence

"Conflict . . .
in ICUs . . .
epidemic
proportions"

13%

ethics consults

MEMORIAL SLOAN-KETTERING CANCER CENTER

J. Oncology Practice (June 2013)

> 33%

ethics consults

University of Michigan Health System

Physician Executive Journal (37 no. 6)

> 50%

ethics consults

Lucile Packard Children's Hospital AT STANFORD

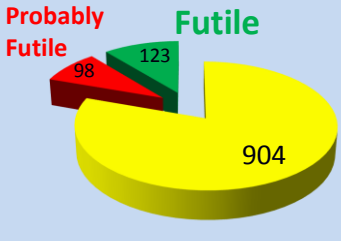
Am. J. Bioethics (Apr. 2009)

Original Investigation

The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care

Thanh N. Huynh, MD, MSHS; Eric C. Kleerup, MD; Joshua F. Wiley, MA; Terrance D. Savitsky, MBA, MA, PhD; Diana Guse, MD; Bryan J. Garber, MD; Neil S. Wenger, MD, MPH

JAMA Intern Med. 2013;173(20):1887-1894. doi:10.1001/jamainternmed.2013.10261
Published online September 9, 2013.



PewResearchCenter

NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

NOV. 21, 2013

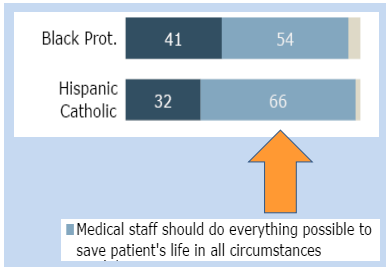
Views on End-of-Life Medical Treatments

Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

Views About End-of-Life Treatment Over Time

% of U.S. adults

	1990	2005	2013	Diff. 90-13
Which comes closer to your view?				
There are circumstances in which a patient should be allowed to die	73	70	66	-7
Doctors and nurses should do everything possible to save the life of a patient in all circumstances	15	22	31	+16
Don't know	12	8	3	-9
	100	100	100	



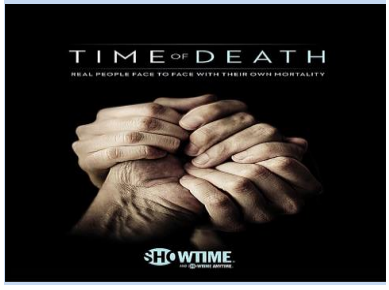
Dispute Resolution

Prevention
Consensus
Intractable

Prevent Disputes

Most patients do NOT want futile treatment

More ACP



Death Café
Columbus, OH

Choosing Wisely®
An initiative of the ABIM Foundation

ASCO® American Society of Clinical Oncology
Making a world of difference in cancer care

Limited effectiveness
Side effects
Options

The New York Times

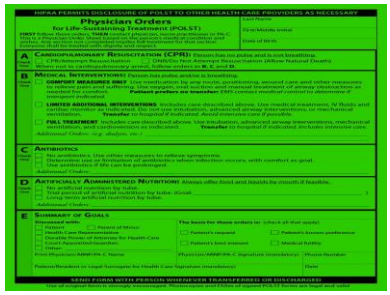
Coverage for End-of-Life Talks Gaining Ground
August 31, 2014, page A1

PUBLIC HEALTH CODE (EXCERPT)
Act 368 of 1978

PART 56A
TERMINAL ILLNESS

333.5651 Short title of part.
Sec. 5651. This part shall be known and may be cited as the "Michigan dignified death act".
History: Add. 1996, Act 594, Eff. Mar. 31, 1997.
Popular name: Act 368

Better ACP



IPDAS
International Patient Decision Aid Standards Collaboration

Nudge

Limits to Prevention

66

PewResearchCenter
NUMBERS, FACTS AND TRENDS SHAPING THE WORLD

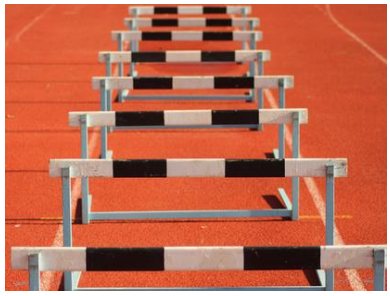
NOV. 21, 2013

Views on End-of-Life Medical Treatments

Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive

18-29	15%
30-49	33%
50-64	38%
65-74	61%
75+	58%

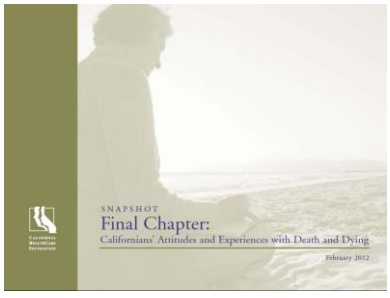
68



30%

want LSMT

70



Disputes **will** arise

72

Consensus

73

Negotiation

Mediation

74

95%

75

Prendergast (1998)

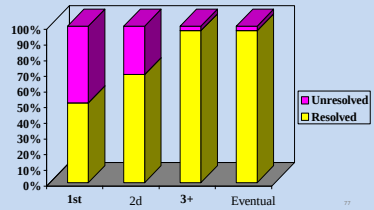
57% agree immediately

90% agree within 5 days

96% agree after more meetings

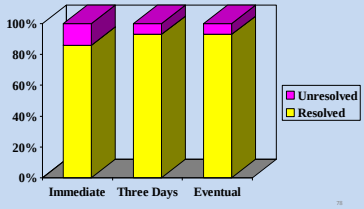
76

Garros et al. (2003)



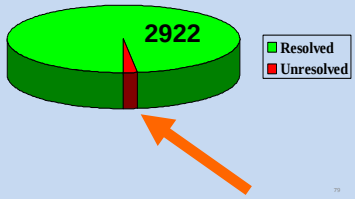
77

Fine & Mayo (2003)

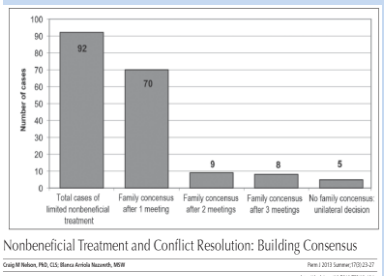


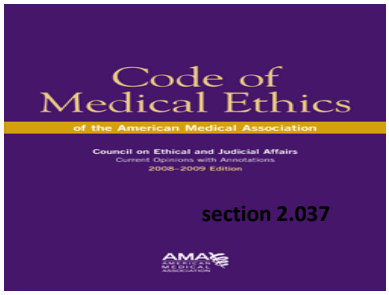
78

Hooser (2006)



79





Consensus

Intractable

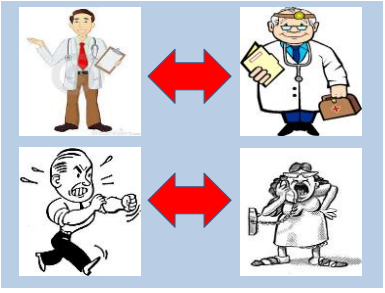
82

5%

83

Switch parties

84



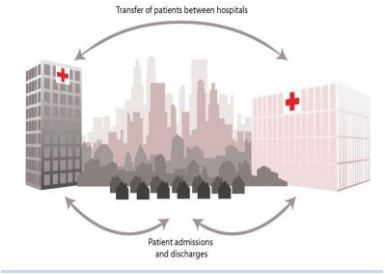
New clinician

New surrogate

86

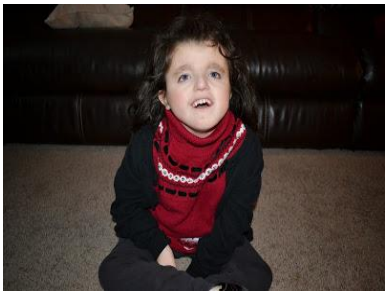
Transfer

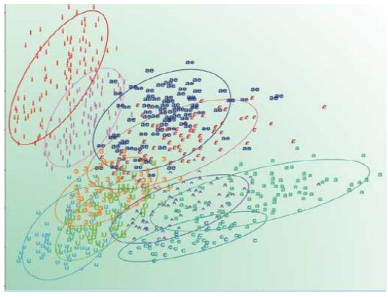
87



Rare, but possible

89





Replace

Surrogate

Substituted judgment

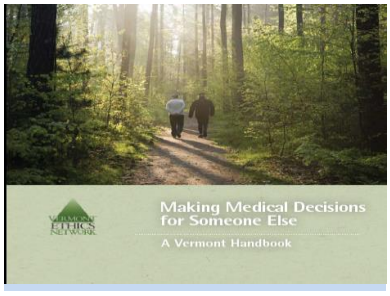
Best interests

~ 60%

accuracy

More

aggressive treatment



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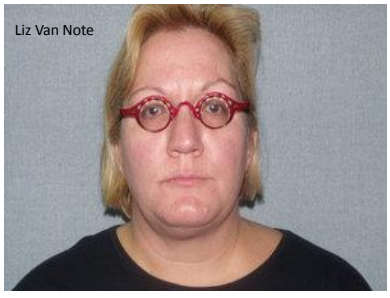


Surrogate	Advance directive
GO	STOP

State of Minnesota
County of Hennepin

FILED
11 FEB -4 PM 1:32
BY: PROBATE/MENTAL HEALTH
FOURTH DISTRICT COURT

District Court
Probate Division
Judicial District: Fourth
Court File No. 27-GC-PR-111-16

In Re: Emergency Guardianship of

Albert N. Barnes,
Respondent

Order Appointing Emergency Guardian

This matter came on for hearing on February 2, 2011 before the District Court on a petition seeking an emergency appointment of a guardian for the Respondent named above. The matter, having been considered by the Court and the Court being duly advised in the premises now makes the following:

FINDINGS OF FACT

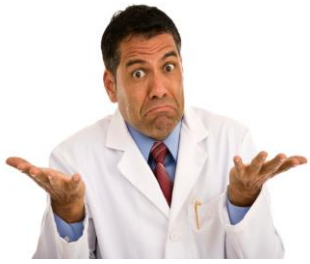
Surrogate	Best interests
GO	STOP

LIMITS of surrogate replacement

110

1

Providers cannot show deviation



2

Surrogates get benefit of doubt

3

Surrogates loyal & faithful

Truly Intractable

117

Covert

Cave-in

Act w/o consent

118

Covert

119

PROPORTION OF PHYSICIANS (n = 726) WHO WITHHELD LIFE-SUSTAINING TREATMENT ON THE BASIS OF MEDICAL FUTILITY

Consent Status	n (%)
Without the written or oral consent of the patient or family	219 (25%)
Without the knowledge of the patient or family	120 (14%)
Despite the objections of the patient or family	28 (3%)

D. Asch, ***Am. J. Resp. Crit. Care Med.*** (1995)

Providers have **won almost every single** damages case for unilateral w/h, w/d

123

IIED

NIED

124

Secretive

Insensitive

Outrageous

125

Consultation expected

Distress foreseeable

126

Cave-in

"follow the . . . SDMs **instead** of doing what they feel is appropriate . . ."

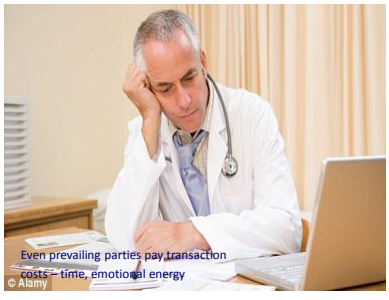
CMAJ 2007;177(10):1201-8

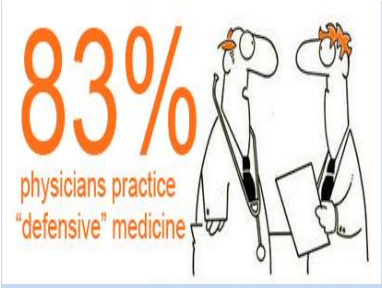
Very few judgments & settlements

Risk > 0

Liability averse

Litigation averse



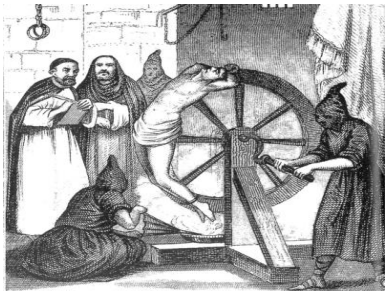


Patient will die soon

Provider will round off

Nurses bear brunt

Bad results



1. ED patients boarded & denied / delayed ICU
2. Community hospital patients denied / delayed ICU

3. ED standby = trauma patients extra transport time
4. Antibiotic resistance
5. Moral distress retention, absenteeism, quality

Stop LSMT *without* consent

Death by Neurological Criteria

M.C.L. 333.1033

An individual . . . . . **is dead** . . . who has sustained ***either***

(1) irreversible cessation of circulatory and respiratory functions, ***or***

(2) irreversible cessation of all functions of the entire brain

total brain failure = death

Legally **settled** since 1980s

Remains settled (legally)

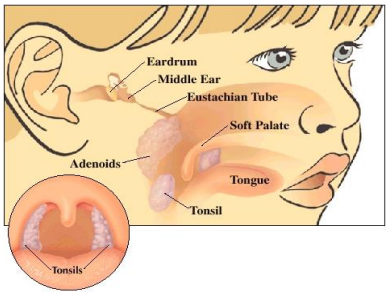
"durable worldwide consensus"

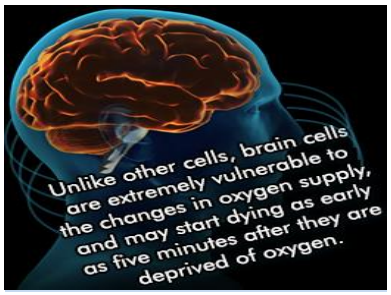
Bernat 2013

Consent **not** required to stop LSMT

Dead → Not a patient

Not a patient → No duty to treat





CHILDREN'S HOSPITAL
& RESEARCH CENTER OAKLAND

Diagnosis confirmed
by 3 CHO clinicians

Paul Fisher

Stanford
Child
Neurology

December 12

↓

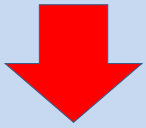
January 5

July 2

↓

July 22

November 26

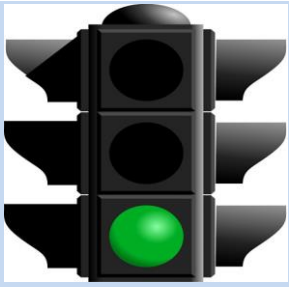


January 26

173

Green

174



175

You may stop LSMT for

any reason

with immunity

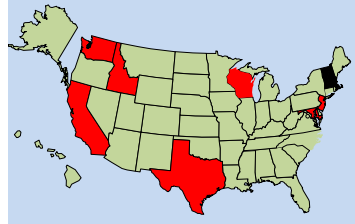
if your HEC agrees

Tex. H&S 166.046

48hr notice HEC

Written decision

10 days to transfer



Resolution 505-08 TITLE: LEGAL SUPPORT FOR NONBENEFICIAL TREATMENT DECISIONS

Author: H Hugh Vincent, MD; William Andereck, MD

Introduced by: District 8 Delegation

Endorsed by: District 8 Delegation

CA

Reference Committee E

October 4-6, 2008

WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

WA

Resolution: C-5 (A-09)

Subject: Legal Protection for Physicians When Treatment is Considered Futile

Introduced by: King County Medical Society Delegation

Referred to: Reference Committee C

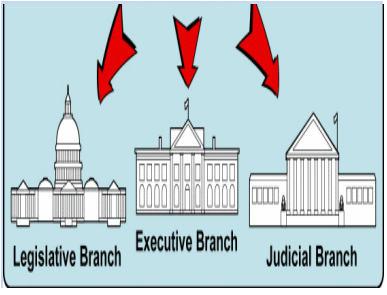
RESOLUTION 1 - 2004
(read about the *action* taken on this resolution)

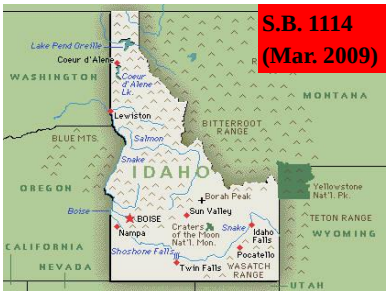
WI

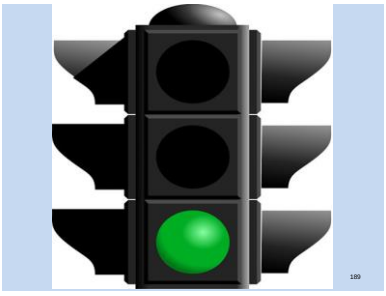
Subject: Futility of Care

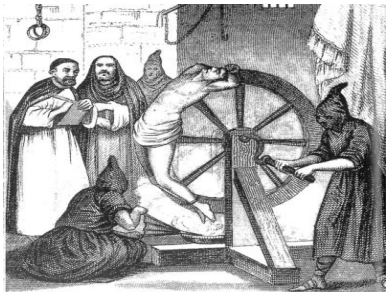
Introduced by: Michael Katzoff, MD and the Medical Society of Milwaukee County

RESOLVED, That the Wisconsin Medical Society, concurrent with a recommendation of the American Medical Association, Medical Futility in End-of-Life Care policy E-2.037, supports the passage of state legislation which establishes a legally sanctioned extra-judicial process for resolving disputes regarding futile care, modeled after the Texas Advanced Directives Act of 1999.









"This is the Massachusetts General Hospital, not Auschwitz."

Cal. Prob. Code 4734(a)

"provider may decline to comply . . . for reasons of **conscience**."

194

Treat 'til transfer

195

Want to refuse

↓

Try to transfer

No transfer

↓

Must comply

Miss. Code § 41-107-3

198

L.B. 564 (2013)

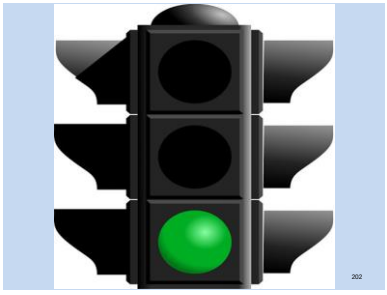
41

H.B. 279 (2013) (over veto)

40

Mich. S.B. 136 (2013)

42



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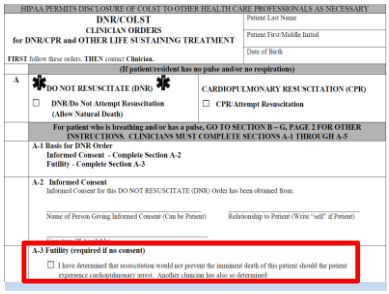


HIPAA PERMITS DISCLOSURE OF COLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

DNR/COLST
CLINICIAN ORDERS
for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT

Patient Last Name
Patient First-Middle Initial
Date of Birth

FIRST follow these orders, **THEN** contact **Clinician.**

(If patient/resident has no pulse and/or no respirations)

A

✱ **DO NOT RESUSCITATE (DNR)** ✱

☐ **DNR/Do Not Attempt Resuscitation (Allow Natural Death)**

CARDIOPULMONARY RESUSCITATION (CPR)

☐ **CPR/Attempt Resuscitation**

For patient who is breathing and/or has a pulse, GO TO SECTION B – G, PAGE 2 FOR OTHER INSTRUCTIONS. CLINICIANS MUST COMPLETE SECTIONS A-1 THROUGH A-5.

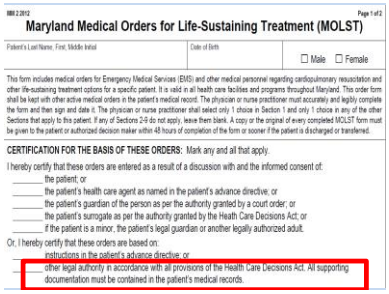
A-1 Basis for DNR Order
Informed Consent - Complete Section A-2
Futility - Complete Section A-3

A-2 Informed Consent
Informed Consent for this DO NOT RESUSCITATE (DNR) Order has been obtained from:

Name of Person Giving Informed Consent (Can be Patient) | Relationship to Patient (Write "self" if Patient)

A-3 Futility (required if no consent)

☐ I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined.



MM.2.2012 Page 1 of 2

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial | Date of Birth | ☐ Male ☐ Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

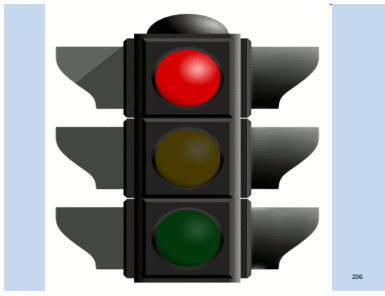
_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

Red

205



206

Consent **always**

207

SDM	Red Light
Agent / POA	Yes
Default surrogate	No
Guardian	No

"A person providing care, custody, or medical or mental health treatment to a patient **is bound** . . . by a patient advocate's instructions . . ."

M.C.L. 700.5511(3)

"If surrogate directs [LST] . . . provider that does not wish to provide . . . **shall nonetheless comply** . . . ."

213

SB 172, HB 309 (2012)

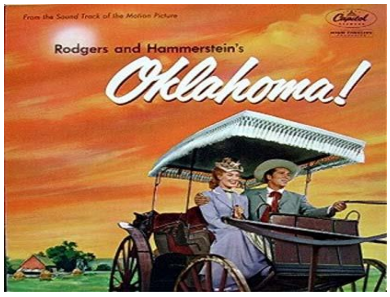
214

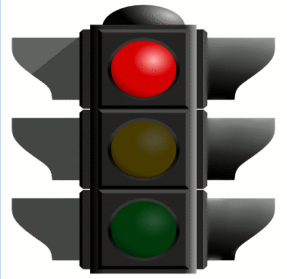
Discrimination in Denial of Life Preserving Treatment Act

215

"Health care . . . **may not be . . . denied** if . . . directed by . . . surrogate"

216





Life & death stakes

Unclear facts

Unclear law

TRO

ADF
ALLIANCE DEFENSE FUND
Defending Our First Liberty

national RIGHT TO LIFE committee, inc.

December 12

↓

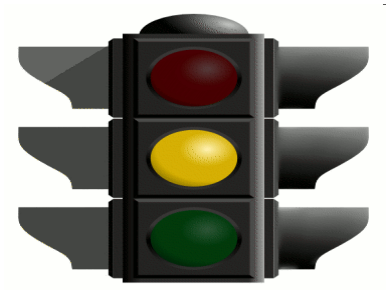
January 5

July 2

↓

July 22

Yellow



"provider . . . **may decline** to comply . . . contrary to generally accepted health care standards . . ."

Cal. Prob. Code 4735

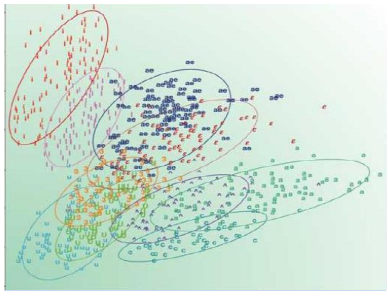
"provider . . . **not subject** to civil or criminal liability or to discipline. . . "

Cal. Prob. Code 4740

"generally accepted health care standards"

Standard of Care S

Standard of Care S



Safe harbor attributes

- Clear
- Precise
- Concrete
- Certain

TX	CA
Measurable	Vague
Purely procedural	Substantive

No substantive criteria

↓

Pure procedural justice

If process is **all** you have, it must have **integrity & fairness**

Notice
Opportunity to present
Opportunity to confront
Statement of decision
Independent decision-maker
Judicial review

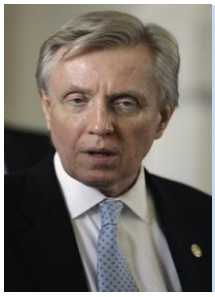
Neutral & independent decision maker

1-5 members 48%
5-10 members 34%

Mostly physicians, administrators, nurses

No community member requirement, like IRB

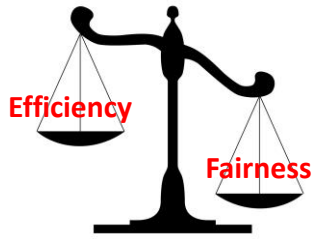
< 10% TX HECs have community member



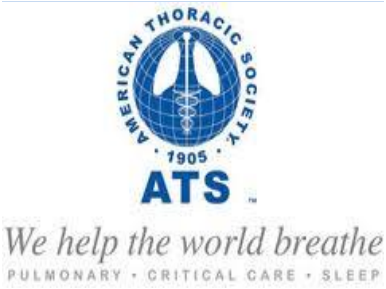
Tex. S.B. 303

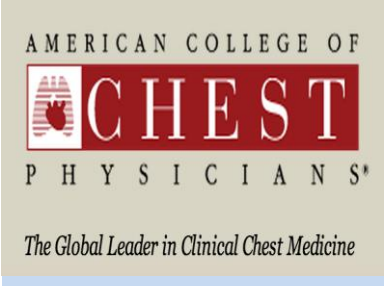
Right concept

But poorly implemented



Conclusion





1. Futile
2. Proscribed / Discretionary
3. Potentially inappropriate

Requests for Futile Intervention	Interventions that cannot accomplish the intended physiological goals	1. Clinicians should explain the reasons why the requested intervention is ineffective and explore the surrogates' reasons for the request. 2. If conflict persists, clinicians should consider a second opinion to help clarify the medical facts and enlist communication experts to help empathically communicate the clinical reasoning behind the refusal and provide psychosocial support.	1. A clinician refuses to perform CPR on a patient with signs of irreversible death (rigor mortis, dependent lividity). 2. A clinician refuses to administer nitroglycerin as treatment for an acute myocardial infarction.

Requests for Prescribed or Discretionary Treatment	Treatments which may accomplish an effect desired by the patient, but for which there are laws, applicable judicial precedent, or public policies that prohibit or permit limitation of their use.	1. Clinicians should work to understand the reason for the request and clearly communicate the rule that governs the request. 2. Clinicians should involve individuals with expertise in interpreting existing regulations to ensure the rule is correctly interpreted and applied. 3. Clinicians should consider involving communication consultants to assist in clear and accurate communication and psychosocial support for the surrogate. 4. Challenges to these rules should be handled by the relevant body that governs the rule.	1. A clinician refuses to circumvent the organ allocation policy to help a critically ill patient get faster access to an organ for transplantation. (proscribed) 2. A clinician refuses to prescribe a lethal dose of barbiturates for a patient who seeks physician-assisted suicide in a location in which such actions are illegal. (proscribed) 3. A clinician refuses to provide ongoing physiologic support for a patient correctly diagnosed as brain dead who is not an organ donor in a state where brain death is recognized as death. (proscribed) 4. In a state which has a statute governing "medically ineffective treatment" (i.e., Maryland), a clinician enters a DNR order for a patient with multiorgan failure and progressive metastatic cancer for whom, to a reasonable degree of medical certainty, CPR would not prevent impending death. (discretionary)

Requests for Potentially Inappropriate Treatment	Treatments that have at least some chance of accomplishing the effect sought by the patient or surrogate and are not proscribed, but clinicians believe that competing ethical considerations justify refusing to provide the requested treatment.	Conflict resolution should be accomplished via the process outlined in recommendations 3 and in Table 4.	1. A clinician believes ICU admission for a person with end-stage dementia and multi-organ failure is inappropriate. 2. A clinician believes it is inappropriate to initiate dialysis in a patient in a persistent vegetative state. 3. A clinician believes it is inappropriate to continue mechanical ventilation in a patient with widely metastatic cancer and progressive multi-organ failure and pressor-induced extremity necrosis

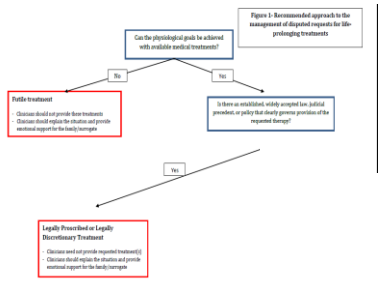
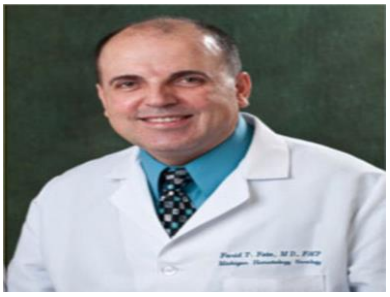


Table 4- Recommended steps for resolution of conflict regarding potentially inappropriate treatments

1)	Prior to initiation of and throughout the formal conflict resolution procedure, clinicians should enlist expert consultation to aid in achieving a negotiated agreement.
2)	Surrogate(s) should be given clear notification in writing regarding the initiation of the formal conflict resolution procedure and the steps and timeline to be expected in this process.
3)	Clinicians should obtain a second medical opinion to verify the prognosis and the judgment that the requested treatment is inappropriate.
4)	There should be case review by an interdisciplinary institutional committee.
5)	If the committee agrees with the clinicians, then clinicians should offer the option to seek a willing provider at another institution and should facilitate this process.
6)	If the committee agrees with the clinicians and no willing provider can be found, surrogate(s) should be informed of their right to seek case review by an independent appeals body.
7a)	If the committee or appellate body agrees with the patient or surrogate's request for life prolonging treatment, clinicians should provide these treatments or transfer the patient to a willing provider.
7b)	If the committee agrees with the clinicians' judgment, no willing provider can be found, and the surrogate does not seek independent appeal or the appeal affirms the clinicians' position, clinicians may withhold or withdraw the contested treatments, and should provide high quality palliative care.

RPA
Renal Physicians Association



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273

References

274

Medical Futility Blog

Since July 2007, I have been blogging, almost daily, to **medicalfutility.blogspot.com**. This blog is focused on reporting and discussing legislative, judicial, regulatory, medical, and other developments concerning medical futility and end-of-life medical treatment conflict. The blog has received over 650,000 direct visits. Plus, it is distributed through RSS, email, Twitter, and re-publishers like Westlaw, Bioethics.net, Wellsphere, and Medpedia.

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